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ABSTRACT

This document is the first volume of a series of reports on the Community Mental Health Center (CMHC) survey project undertaken to assess the impact of the Alcohol, Drug Abuse and Mental Health Services block grant program on the delivery of mental health services to older persons. Chapter I presents an introduction to and background information on the CMHC survey. Chapter II describes a mail/telephone survey of 233 CMHCs in 41 states which requested information on the impact of the block grant, specialized aging programs, funding sources, the client population, services provided to older clients, and professional and support staff. Chapter III focuses on a series of in-depth interviews and site visits to CMHCs and to Area Agencies on Aging (AAAs) designed to obtain more complete information about the impact of the block grant on CMHC programs and age-related services, and the nature and extent of the interagency contact and cooperation between CMHCs and AAAs. Chapter IV presents 16 recommendations for federal, state, and local reforms to improve the delivery of mental health services to older persons. The recommendations discussed are based on mental health recommendations of the 1981 White House Conference on Aging and on the following major survey and site visit findings: (1) the block grant has had an adverse impact on CMHCs; (2) the aged are underserved by CMHCs; (3) older adults in racial and ethnic minorities are severely underserved; (4) there have been decreases in specialized aging programs; and (5) there is little interagency cooperation between the mental health and aging services networks. An executive summary of the report is included. (NB)

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Mental Health Services for the Elderly:

Report on a Survey of

Community Mental Health Centers

Volume I

by

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Action Committee to Implement the Mental
Health Recommendations of the 1981 White
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The Retirement Research Foundation

1984

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This is the first volume of a three volume report. Volume II presents excerpts from the reports on site visits to Community Mental Health Centers and Area Agencies on Aging, the survey questionnaire, guidelines for site visit interviews, and the levels of statistical significance for the data comparisions. Volume III, to be published in Fall 1985, will present the two year follow-up resurvey of Community Mental Health Centers to determine the on-going impact of the Alcohol, Drug Abuse and Mental Health Services block grant on the provision of mental health services to older persons.

Volumes II and III may be obtained by writing to:

The Action Committee to Implement the Mental
Health Recommendations of the 1981 White
House Conference on Aging
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EXECUTIVE SUMMARY

Action Committee

The "Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging" is an interdisciplinary organization concerned with issues related to the quality, coordination, delivery and financing of mental health services for older Americans. The "Action Committee" is chaired by former U.S. Department of Health, Education and Welfare Secretary Arthur S. Flemming, and is funded by a grant from the Retirement Research Foundation.

The Action Committee has been, since its inception, concerned with the problems associated with the delivery of outpatient mental health services to older persons and in implementing the mental health recommendations of the 1981 White House Conference on Aging. The Action Committee identified the following areas for priority attention: the financing of mental health care - expansion of Medicare mental health benefits; the coordination of the delivery of local mental health and psychosocial services to older persons; the assurance that the emotional needs of patients and families are adequately addressed in the Department of Health and Human Services hospice regulations; an exploration of the treatment and legal rights of mentally ill nursing home patients; the development of accreditation standards and mental health training modules for the network of homecare providers; and the expansion of public education and consumer education, particularly as it related to the stereotyping of the aged. The Action Committee has initiated a series of projects in each of these priority areas.

Survey and Site Visits

When the Action Committee began to focus on the 1981 White House Conference on Aging recommendations calling for increased Community Mental Health Center (CMHC) services to older persons and for the coordination of local service delivery by the mental health and aging services networks, it became apparent that under the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant program, enacted as part of the 1981 Omnibus Budget and Reconciliation Act, there would be no mechanism to measure the scope of specific CMHC services to older persons or the impact of the block grant program on such services. The ADMS block grant provided little direction to states on program priorities (such as specialized aging programs), allocation of funds, or accounting requirements. As federal reporting requirements had been discontinued, there were no national data available to assess changes in service provisions due to the block grants. It was, therefore, necessary to undertake an independent survey of CMHCs to collect current data on local programs.

The Community Mental Health Center survey project was undertaken to assess the impact of the block grant program on the delivery of mental health services to older persons. The project consisted of two phases: first, a

mail/telephone survey of Community Mental Health Centers, with special attention given to the delivery of services to the aged, and second, a series of in-depth interviews, visiting CMHCs and Area Agencies on Aging (AAA). In the first phase of the project the Action Committee, in conjunction with the National Council of Community Mental Health Centers, mailed a questionnaire to 649 CMHCs requesting information on the impact of the block grant, specialized aging programs, funding sources, the client population, services provided to older patients, and professional and support staff. A total of 233 responses, representing 36% of the CMHCs, were obtained from 41 states.

The following is a summary of the survey findings:

- o 48% of the CMHCs surveyed reported adverse effects due to the ADMS block grant.
- o The elderly remain an underserved group, receiving only 6% of CMHC services.
- o There has been a decrease in the number of specialized aging programs delivered through CMHCs.
- o There has been a significant decrease in federal support for mental health care. Local and private support has been employed to restore a portion of the loss in funding.
- o Clinical service staff have been adversely affected.
- o The adverse effects of the block grant program are being felt nationwide.

The second phase of the project entailed detailed site visit interviews with selected CMHCs and AAAs. The purpose of these interviews was to obtain more complete information about the impact of the block grant on CMHC programs and age-related services, and on the nature and extent of the interagency contact and cooperation between CMHCs and AAAs.

In the CMHC interviews, information was obtained about the impact of the block grant on the overall operation of the Centers and the composition of the client population; the effects of the deinstitutionalization movement on overall client and older client populations; the Centers' perceptions of mental illness prevalence rates among the elderly and the reasons for under-utilization of mental health services by older persons; the specialized aging programs and the specific services provided older clients, or why specialized programs were not provided; and the frequency of interaction between the CMHC, the AAA, and other community and state organizations delivering mental health and/or aging services.

The AAA interviews were more general in nature than those with CMHCs. Information was obtained on the background of aging program services, funding patterns and data on any mental health related services, the nature of mental

health problems experienced by local older clients and the impact of that clientele on existing programs, the need for staff training in mental health and aging, and the nature and extent of their interaction with CMHC and other mental health and/or aging programs providing direct services to mentally ill elderly.

The following is a summary of the site visit findings:

- o CMHCs reported adverse effects on their activities related to block grant funding.
- o Block grants had a negative impact on geriatric services.
- o CMHCs reported little contact with Area Agencies on Aging.
- o Aging programs are aware of the mental health service needs of their clients.
- o AAAs and CMHCs reported almost no coordinated service delivery and little routine interaction.
- o There is a need for cooperation between the mental health and aging services networks.
- o There is need for in-service mental health training for aging service staff.

Recommendations

In response to the major survey and site visit findings -- the adverse impact of the block grant program on CMHCs, that the aged remain an underserved population with CMHCs, that racial and ethnic minority elderly are severely underserved, that there have been decreases in specialized aging programs, and that there is little interagency cooperation between the mental health and aging services networks -- and the mental health recommendations of the 1981 White House Conference on Aging, the Action Committee presents the following 16 recommendations for federal, state, and local reforms:

Recommended Federal Reforms

- o Abolish the block grant system of service funding.
- o Reinstate a categorical system of mental health service funding.
- o Expand Medicare mental health benefits to a level which parallels medical benefits coverage.
- o Amend the Older Americans Act to assure a coordinated approach between Area Agencies on Aging and Community Mental Health Centers in meeting the mental health and psychosocial needs of the elderly.

- o The federal government should take administrative action to assure that the interagency agreement previously developed between the National Institute of Mental Health and the Administration on Aging mandating mental health and aging service systems cooperation in the development and provision of psychosocial services to the elderly be implemented in an expeditious manner.

- o Implement the Older Americans Act requirement that Title IV grants for mental health demonstration programs for older adults require the incorporation of the full range of mental health service needs of the aged.

Recommended State Reforms

- o State Agencies on Aging and State Departments of Mental Health should take administrative action to assure coordination and cooperation in their planning, development, resource allocation, and service delivery, in order to provide and support an adequate continuum of psychosocial services to meet the diverse needs of older adults.

- o State governments should enact legislation to establish specifically targeted programs addressing the mental health needs of the elderly in all state mental health systems.

- o The directors of State Agencies on Aging, State Departments of Mental Health, and directors of local Area Agencies on Aging and Community Mental Health Centers should assume an advocacy role on behalf of comprehensive mental health services for older adults before state legislatures, the Administration, and the Congress.

- o Full mental health coverage should be restored and maintained under Medicaid at the 1981 level (with allowances for inflation).

- o State Agencies on Aging and State Departments of Mental Health should initiate in-service training programs in mental health and aging at both the state and local levels for mental health and aging service personnel.

Recommended Local Reforms

- o Local Area Agencies on Aging and Community Mental Health Centers (and other mental health and aging service providers) should initiate formal inter-system coordination and interaction for the assessment, planning, development, and delivery of comprehensive mental health services to the aged.

- Community Mental Health Centers, and other public and privately funded mental health programs, should insure that adequate and suitable services are being delivered and allocated on an equitable basis to the aged in the community and particularly to the minority elderly.

- Local aging networks and the mental health system should initiate joint training sessions for mental health and aging service providers at the community level.

- Joint case management systems, involving both the aging and mental health networks, should be developed at the community level.

- Interagency community action networks should be established at the local level to develop cooperative planning and program development for a continuum of mental health services for the aged.

As the purpose of the research project was to assess the impact of block grants on the delivery of mental health services to the elderly in this country, the report focused primarily on deficiencies in the mental health system and current mental health policies. Nevertheless, the Action Committee would also like to formally recognize and commend the substantial contributions that Community Mental Health Centers and Area Agencies on Aging have made to the health and well-being of our nation's elderly through the dedication and hard work of their mental health professionals.

The full report is published in two volumes. Volume I presents the introduction and background to the survey, the results of the survey of Community Mental Health Centers, brief summaries of the site visits to Community Mental Health Centers and Area Agencies on Aging, and recommendations for federal, state and local reforms. Volume II presents excerpts from the reports on site visits to Community Mental Health Centers and Area Agencies on Aging, the survey questionnaire, guidelines for site visit interviews, and the levels of statistical significance for the data comparisons.

Volume III, to be published in Fall 1985, will present the two year follow-up resurvey of Community Mental Health Centers to determine the on-going impact of the ADMS block grant on the provision of mental health services to older persons.

Chapter I

INTRODUCTION AND BACKGROUND

Action Committee

The "Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging" is an interdisciplinary group concerned with issues and problems related to the quality, coordination, delivery and financing of mental health services for older Americans. The "Action Committee" is chaired by former U.S. Department of Health, Education and Welfare Secretary, Arthur S. Flemming, and is funded by a grant from the Retirement Research Foundation.

Scope of the Issues

The Action Committee has been, since its inception, concerned with the problems associated with the delivery of mental health services to older adults. The nature of these problems are suggested by the following recommendations from the 1981 White House Conference on Aging.

> Congress and the Administration should expand and develop adequate and appropriate mental health services for older adults (Recommendation #45).
>
> There is a need to provide for a community-based continuum of care system to maintain and prolong an independent, best possible quality of life for our elderly population (Recommendation #163).
>
> Community Mental Health Centers should be required to allocate mental health professional and support staff and funds proportionate to the percentages of older adults in the catchment area (Recommendation #120-A).
>
> Mental health and health care servces to the elderly should be provided with a sensitivity to and awareness of ethnic and cultural difference (Recommendation #161).
>
> The limitation on Medicare reimbursement for outpatient and inpatient mental health services for the elderly should be set at the same level as for other medical services (Recommendation #132).
>
> All personnel involved in the delivery of . . . services should be required to have gerontological and/or geriatric training (Recommendation #429).

It should be noted, however, that the 1981 White House Conference delegates were not the first to identify such mental health issues. The lack of an effective outpatient service delivery mechanism for mentally ill older adults was also cited in the Report of the 1971 White House Conference on Aging; in the findings of a 1979 "Conference on Mental Health and the Elderly" sponsored by the House Select Committee on Aging; by the 1978 President's Commission on Mental Health; by the "Report of the Mini-Conference on the Mental Health of Older Americans" (White House Conference on Aging, 1982), and, most recently, in a 1982 study by the U.S. General Accounting Office entitled "The Elderly Remain in need of Mental Health Services" (GAO, 1982). All of these reports, along with others too numerous to cite, have decried the fact that the primary mental health service system has not met the mental health needs of America's older adults.

The Elderly are in Need of Mental Health Services

The need for geriatric mental health services has been well identified and defined. The President's Commission on Mental Health (1978), for instance, found that 15% to 25% of the nation's elderly -- between 3.7 and 6.0 million individuals -- have significant mental health problems, and they estimated that up to 30% of this older population experience some form of depressive symptomatology (White House Conference on Aging, 1982). While the elderly comprised 11.3% of the 1980 population, they committed 16.9% of the nation's suicides (McIntosh, 1983, in Press; McIntosh, Hubbard & Santos, 1981). Alcoholism among the elderly is estimated at 8-16% (Kay & Bergman, 1980) and between 50-75% of the nation's nursing home residents manifest emotional or behavioral dysfunction (White House Conference on Aging, 1982). What is particularly unfortunate about the lack of mental health services to the aged is that many of these problems could be successfully treated on an outpatient basis.

While this report in no way is intended to minimize the problems of older adults suffering from Alzheimer's disease or other organic brain syndromes, it must be noted that the prevalence of Alzheimer's, chronic brain syndrome, and other disorders catalogued as dementia, is comparatively low. Overall, only 5% of older Americans suffer from such chronic and irreversible conditions, although the prevalence rates for these disorders dramatically increase in the age group over 80 (White House Conference on Aging, 1982). However, the vast majority of elderly suffering from emotional problems experience depression and other conditions which can be treated on an outpatient basis, and may be effectively reversed.

The Elderly are Underserved by the Mental Health System

Given the high rate of short-term and reversible mental health problems of the older population it might be expected that they would appear as a significant proportion of the outpatient clientele served by Community Mental Health Centers and other outpatient mental health facilities. Unfortunately, this has not been the case on a national basis even though National Institute of Mental Health data has shown that the percentage of elderly Community Mental Health Center (CMHC) clients did increase slightly between 1971 and

1982, from 3.4% to 6.0%. However, this is still well below the 11.3% that would be expected solely on the basis of the percentage of elderly clients in the general population. Since the percentage of older persons with some type of mental health related problem has been estimated to be approximately 25% (President's Commission on Mental Health, 1978) the 6.0% is even more serious than it might appear on a strictly demographic basis. Figures on the percentage of older persons treated by private practitioners are equally disappointing, as less than 4% of such patients are from the elderly population (VandenBos, Stapp, & Kilburg, 1981).

The special mental health needs of racial and ethnic minority elderly have been sorely neglected by both public and private mental health systems. The community mental health movement of the 1960s and 1970s largely ignored the minority elderly; their service needs were never adequately assessed and prevention and treatment programs were not designed to deal with their unique problems. Consequently, the minority aged continue to be significantly underrepresented in the utilization of mental health services (Kobata, Lockery & Moriwaki, 1980).

Factors Contributing to the Underservice of the Elderly

It is not the intent of this report to define and fully explore to reasons for the under-utilization of outpatient mental health services by older adults. However, it should be noted that there are at least two major federally-imposed impediments to adequate mental health care for older adults.

The first impediment lies in the Medicare provisions for outpatiaent mental health care which contain disincentives, for both patients and providers, for adequate mental health services for the aged. Medicare limits reimbursement for outpatient mental health care to $250 annually and requires that the patient pay 50% of the cost of mental health care (as opposed to only 20% of the cost for physical health care). This imposes a significant financial burden, particularly on the older patient. In addition, direct Medicare reimbursement is limited to psychiatrists and to CMHCs associated with psychiatric or general hospitals. Free-standing CMHCs, which constitute 90% of the total, and non-physician providers are prohibited from receiving direct reimbursement. This burdensome restriction not only serves to deny treatment to the aged, but also tends to increase health care costs by reimbursing only the more expensive forms of treatment.

The second impediment to effective outpatient mental health care for older Americans is the lack of concerted federal (and, consequently, state and local) government recognition that older adults require an array of integrated psychosocial services. A study by the General Accounting Office (GAO, 1982) found that, while in many cases older adults require the same mental health services as younger age groups (e.g., diagnostic services, treatment planning, crisis intervention, psychotherapy, and so forth), older patients also require specialized facilitative and support services -- such as outreach, home visits, and transportation. The GAO study also identified the need for specialized interdisciplinary and interagency cooperation to assure adequate

psychogeriatric assessment of patients' physical and social (as well as mental health) needs. It also cited the need to develop and implement comprenensive case management strategies to facilitate the older patient's interaction with other community-based organizations, and particularly those servces provided through the Area Agencies on Aging (AAA).

The "mental health" service system (the CMHC) and the "aging" service system (the AAA) are, unfortunately, two discrete and non-coordinated governmental organizations at the present time with only the former being directed to the psychological needs of the elderly. The systems are largely dichotomized at the federal, state, an local levels.

As indicated below, there have been marginal efforts on the part of the federal government to encourage the development of specialized psychosocial services for the elderly. However, such efforts have produced only a few model programs. During the site visits undertaken by the Action Committee, it was found that CMHC-AAA interaction was, at best, occasional and often limited to crisis management. The federal government appears to be responsible, in large part, for this state of affairs as there has been no strong national mandate for a coordinated interagency service delivery system.

Federal Initiatives for Mental Health Care for the Elderly Prior to the Alcohol, Drug Abuse and Mental Health Services Block Grant

The Community Mental Health Centers Act of 1963 is the primary federal initiative for the provision of community-based mental health care. When the program was launched, the CMHCs were envisioned by the Congress as the desired alternative to institutional care -- as the centerpiece of the deinstitutionalization movement of the 1960s. Comprehensive Community Mental Health Centers were to provide all necessary services to assure a continuum of treatment that would allow patients to remain in (or return to) their homes and communities.

While CMHCs were initially mandated as comprehensive care centers to provide services to individuals regardless of age, there emerged, during the 1970's a trend toward the provision of services for special target populations. Consequently, in 1975 Congress mandated that newly funded CMHCs should provide specialized aging services and this requirement was re-emphasized in 1978 amendments to the Community Mental Health Centers Act. While there has been some progress by CMHCs in expanding their aging programs, neither the 1975 nor the 1978 amendments provided adequate incentives for full implementation of the Congressional directives. Accordingly, in enacting the Mental Health Systems Act of 1980, the Congress provided for special staffing and coordination grants for CMHCs with identified aging programs. This step was viewed with optimism by mental health and aging professionals since such financial incentives were intended to encourage CMHCs to implement categorical aging problems. Unfortunately, the Mental Health Systems Act was never implemented, as it was superceded by the current mental health block grant program.

While there has been at least some attempt on the part of Congress to encourage CMHCs to develop specialized categorical aging services, this has not been the case for Area Agencies on Aging in terms of their concern for the mental health needs of their clients. In fact, in its preamble the Older Americans Act does identify mental health as an area of need, and the 1981 reauthorization of the Act cites mental health services as a priority under the Commissioner on Aging's Title IV discretionary demonstration program. However, to date the discretionary program has produced very few funded mental health projects. Moreover, mental health service has not been emphasized as core support service to be provided through the local Area Agencies network. Community Mental Health Centers, therefore, remain the only community focal point of mental health care for the elderly.

The Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant

Enacted in 1981 under the Omnibus Budget and Reconciliation Act, the ADMS Block Grant Program reflects the Reagan Administration's philosophy that mental health servces should be planned and implemented by states rather than the federal government. Like the social services and other block grant programs, the new law provides relatively little direction to states on program priorities, allocation of funds, or accounting requirements. While the mental health block grant language generally directs states to use funds for the "identification and assessment of mentally ill elderly individuals and the provision of appropriate service to such individuals," there are no mandates for specialized geriatric services. Further, there are no specific reporting requirements which would hold state and local agencies accountable for the delivery of services to meet the stated directive. Although the Act does allow the Secretary of the Department of Health and Human Services to impose uniform program reporting requirements on states, both Secretary Schweiker and Secretary Heckler have opted to waive such requirements.

The ADMS Block Grant Program fails to accommodate the specialized needs of the elderly. A major problem with the block grant approach (with respect to the elderly and other special needs populations) is the absence of a requirement for the uniform availability of services. It remains at the discretion of the state as to whether or not older clients are to be targeted for special services. Given this nondirective ("shotgun") approach, adequate provision of needed services cannot be assured. As the previously mentioned GAO study has indicated, a categorical approach to geriatric services is preferable, in that it can both mandate and provide for accountability related to specialized services to older clients. The block grant program, by its very nature, is less likely to result in programs that will meet the specialized mental health needs of older adults. In fact, data collected by the Action Committee suggest that, under the block grant program, already established geriatric programs are increasingly being discontinued. Accordingly, it is our belief that without a federally mandated categorical program, the mentally impaired elderly will continue to be inadequately served by Community Mental Health Centers.

The repeal of the Mental Health Systems Act of 1980 and the initiation of the block grant program has had other consequences for mental health services that will not be easily remedied. With the creation of the ADMS block grant, mental health services were eliminated as a mission of the National Institute of Mental Health (NIMH). As a result, virtually the entire mental health service infrastructure of the Institute was eliminated, and the regional offices, which had offered technical assistance to state and local mental health agencies in the development of alcoholism, drug abuse and mental health treatment programs, were closed, and their staff positions terminated. Thus, the scope of NIMH activity has been narrowed to the review and funding of research grant proposals. Since 1981, the Administration has reduced the NIMH staff by 51% (over 400 positions), with an additional 17% reduction anticipated for 1985.

Concurrent with the elimination of mental health serices, the Administration has also sought to eliminate clinical training support at NIMH for the core mental health professions (clinical nursing, psychiatry, psychology, social work). This program also includes funds for the Minority Fellowship Programs, which support the training of minority students in the mental health professions. Funding for clinical training has been reduced from $61.9 million in 1981, to $45.4 million in 1982, to zero by the Administration for 1983, 1984, and 1985. However, Congress has voted to restore $21 million to the 1983 and 1984 budgets.

The long-range effects on mental health services of the elimination of the NIMH mental health services divisions and the reduction in support for clinical training will be substantial. Even a restoration in funding to pre-block levels would require years to rebuild a staff with the level of expertise in mental health policy development and program planning which was present in the division and regional centers once operated by NIMH. This means that currently, and in the immediate future, states will have to develop their mental health programs without the benefit of the technical expertise and assistance that they once had available.

The reduction in clinical training support has served to reduce the number of students attracted to the mental health professions, and will undoubtedly contribute to the shortage of trained professionals that are available to meet the mental health needs of this country's growing aged population. This will be particularly true with respect to the training of racial and ethnic students for work with the increasing number of minority elderly.

Rationale for the Present Survey

When the Action Committee began to focus on recommendations calling for increased CMHC services to older adults from the 1981 White House Conference on Aging, it became apparent that the block grant system provided no mechanism for measuring the scope of specific CMHC services to older adults or assessing the general impact of the block grant program on such services. It was also obvious that because federal program reporting requirements had been arbitrarily discontinued, there would be no national data available to

determine changes in service provision. The Action Committee, therefore, decided to undertake an independent survey of CMHCs to obtain current data on the impact of block grant on local programs.

While there have been many independent studies that have measured the influence of Reagan Administration policies on a range of domestic programs, this survey is the only one that deals with mental health services for older adults. The Action Committee hopes that these findings will be useful to federal, state and local policymakers, as well as national, state, local and grassroots organizations concerned with mental health and aging.

Chapter II

SURVEY OF COMMUNITY MENTAL HEALTH CENTERS

Summary of Survey Findings

- 48% of the CMHCs surveyed reported adverse effects due to the ADMS block grant.
- The elderly remain an underserved group, receiving only 6% of CMHC services.
- There has been a decrease in the number of specialized aging programs delivered through CMHCs.
- There has been a significant decrease in Federal support for mental health care. Local and private support has been employed to restore a portion of the loss in funding.
- Clinical services and staff have been adversely affected.
- The adverse effects of the block grant program are being felt nationwide.

Introduction to the Survey

The Community Mental Health Centers survey project, one of a number of Action Committee activities, consisted of two phases. The first phase involved a mail/telephone survey of Community Mental Health Centers (CMHCs), with special attention being given to securing information on the delivery of services to the aged. The results of the first phase will be presented in this chapter. The second phase included a series of site visits to 11 locations involving CMHCs and Area Agencies on Aging (AAAs). The results of the second phase will be presented in Chapter III.

Methods

A survey instrument was developed which contained seven sets of questions (Volume II). The first question asked if the impact on the local program of the block grant was viewed as positive, negative, or neutral. If it was viewed as negative, the respondent was asked to indicate which program functions had been adversely affected (staff support, clinical services, administration, clinical record keeping, or other). The second question asked if the center currently or ever had a specialized aging program. The third question called for a breakdown of federal, state, local, private, and

other funding sources, both for 1983 (post-block grant) and 1981 (pre-block grant) years. The fourth question called for a breakdown of the total client population by age and sex, and requested data on the race/ethnicity of the older client population. The fifth question sought data on services provided to older clients for the 1983 budget year and the pre-block grant (1981) budget year, including the percentage of CMHC visits and the percentage of direct care, prevention, consultation and education, and specialized services rendered to older clients as compared to other age groups. Question six requested information on full- and part-time professional and support staff for both the pre-block and post-block budget years, including the number of racial/ethnic minority staff members. Question seven asked if the center would agree to a more in-depth interview at a later time.

The questionnaire was mailed to 649 Community Mental Health Centers obtained from a list of CMHCs provided by the National Council of Community Mental Health Centers (NCCMHC). A cover letter, signed jointly by the Executive Director of the NCCMHC and the Chair of the Action Committee, accompanied each survey form. A second mailing took place four weeks after the first mailing.

A total of 233 responses, representing 36% of the original mailing, were ultimately obtained. The first mailing (including the "reminder") produced 103 usable returned questionnaires (or 44% of the final 233). In order to obtain a larger sample, a randomly chosen group of the non-responding CMHCs were contacted by telphone. This resulted in 35 additional CMHCs returning the questionnaires (representing 15% of the final 233 respondents). Data on the remaining 95 CMHCs were obtained through telephone interviews (or 41% of the final sample).

Data were analyzed by means of analysis of variance, t-tests, and the chi-square technique using an SPSS statistical program (significance levels are reported in Volume II).

The sample of Community Mental Health Centers

The survey data included information about CMHCs in 41 states, with the largest number of respondents being from Ohio (22), Pennsylvania (15), Illinois (11), and Indiana (11). The CMHC locations, based on Census Bureau regional definitions, were as follows: Northeast, 22%; North Central, 31%; South, 34%; and West 13%.

Overview of Results

Forty-Eight Percent of CMHCs Reported Adverse Effects Due to the Block Grant

In response to the first question -- "Has your Community Mental Health Center been adversely affected due to the initiation of the ADMS block grant program?" -- 109 respondents (or 48% of those responding to this item) indicated "yes", while 119 respondents (or 52%) indicated that there had been "no adverse effects". When the block grants were proposed originaly, the Reagan Administration indicated that there would be "no" or "little" adverse

effect, so that the expected number reporting adverse effects should have been few in number or zero.

The Number of Client Visits to CMHCs Were Approximately the Same Before and After Funding Reductions

The mean number of reported annual visits to CMHCs for the study sample was 32,886 for the 1983 budget year with a nearly identical average being reported for the previous year. Thus, there was no significant reduction in the annual total number of visits from the pre-block grant (1981) to the post-block grant (1983) period (*1 -- reported in Volume II).

The Aged Remain an Underserved Population

The percentage of visits by older people for the total sample (N = 233) of studied CMHCs remained constant (at about 6%) from the pre-block grant period (1981) to the post-block grant period (1983). The range of these percentages varied from 0 to 33% across CMHCs for FY 83 and from 0 to 23% for the preceding year. Thus, the elderly generally were underserved by CMHCs both before and after the block grant since they represent approximately 11% of the population but receive an average of only 6% of the reported care.

The figures reported for the various types of services provided to older clients were virtually identical for the pre-block grant period (1981) and 1983 budget periods. These data can be summarized as follows: direct care or treatment (as noted above, mean = 6%, range 0-33%); prevention, consultation and education (mean = 12%, range 0-75%); and special services such as outreach, home care, and case management (mean = 17%, range 0-100%). These data indicate that the elderly received and continue to receive more indirect and suportive services than direct care and treatment. The large variation across CMHCs in the range of percentages for the various services suggests considerable inconsistency in the provision of geriatric services.

Decrease in Specialized Aging Programs

The majority of the centers (127, or 55% of those responding to this item) reported having an identifiable aging program during the 1983 post-block grant budget year as compared to 149 (or 64%) in 1981 prior to the block grant. Thus, the percentage of centers with specialized aging programs have declined since the implementation of the block grant.

For the current sample, the number of CMHCs starting aging programs increased steadily from 1972 to 1978, but subsequently declined sharply. The number of CMHCs terminating an existing specialized aging program increased from an extremely low rate from 1977 through 1979, to an accelerated rate from 1980 to 1983.

Funding Sources Remain Unchanged

The questionnaire requested information on the sources of CMHC funds, whether or not they received any federal, state or local government funding, and information on other private or public financial support. This information was difficult to obtain since 34% of the returned questionnaires failed to answer one or more of these questions. However, there was a better response to the telephone interviews. Comments on the questionnaire from several CMHC directors (as well as from the telephone interviews) indicated that often they did not know the original source of their federal or state funds since, under the block grant program, they are funded through state departments of mental health. For example, several respondents indicated on the questionnaire that ADMS block grant funds were from state rather than federal sources of revenue.

The funding sources, as reported by the CMHCs, can be summarized as follows:

All Federal Funding

Current	Pre-Block Grant
145 CMHCs (69%) received	146 (75%) received
64 CMHCs (31%) did not	49 (25%) did not
Not Reporting: 24 CMHCs	Not Reporting: 38 CMHCs

Federal ADMS Funding Only

Current	Pre-Block Grant
123 (63%) received	95 (62%) received
72 (37%) did not	58 (38%) did not
Not Reporting: 38 CMHCs	Not Reporting: 80 CMHCs

State Funding

Current	Pre-Block Grant
189 (93%) received	173 (92%) received
15 (7%) did not	14 (8%) did not
Not Reporting: 38 CMHCs	Not Reporting: 46 CMHCs

Local Funding

Current	Pre-Block Grant
177 (87%) received	161 (87%) received
27 (13%) did not	25 (13%) did not
Not Reporting: 29 CMHCs	Not Reporting: 47 CMHCs

Private and Other Funding

Current	Pre-Block Grant
196 (95%) received	176 (93%) received
10 (5%) did not	13 (7%) did not
Not Reporting: 27 CMHCs	Not Reporting: 44 CMHCs

It is apparent that CMHCs are receiving funds from a variety of sources, and the pattern of funding has remained constant since the initiation of the block grant program. However, these results must be regarded with some caution because of the number of CMHCs not reporting this information.

The multiple sources of funding, combined with the confusion about the source, serves as an impediment to those who plan and advocate for mental health services for the aged. The CMHC directors cannot be sure of their funding for the next fiscal year, and, therefore, are likely to be cautious in the development of innovative and outreach services to meet the needs of the elderly. At the same time, those who serve as advocates on behalf of geriatric services have difficulty in knowing where to focus their efforts in terms of local, state or federal levels.

Decreased Financial Support

More detailed information was obtained by examining the actual levels of funding received by CMHCs from each of the various sources. The average amounts received (in thousands) from each source were:

Source	Current	Pre-Block Grant	Difference
Federal-total	$ 354,407	$ 490,928	$-136,521
State	743,809	742,877	932
Local	310,029	262,909	47,120
Private & Other	501,563	448,032	53,531
Total	$1,909,808	$1,944,746	$ -34,938

The above figures show that the total level of CMHC funding decreased only an insignificant amount from the 1981 to the 1983 budget year. However, normal inflationary trends would lead to the expectation of at least a slight increase in funds. In contrast, federal funding of CMHCs were found to have decreased by $136,521 during the same period and this figure is statistically significant. Of this amount, $86,789 of the loss was from ADMS funds (which decreased from an average of $351,840 to $265,051) and the balance was from other federal sources.

The amount of funds from all other funding categories -- state, local, private and other -- did increase slightly, but not enough to fully offset the loss of federal support. When the effect of general inflation is introduced into the picture, the size of the loss, of course, is increased.

Insufficient Data Collected on Gender and Minorities

Incomplete information was received on the delivery of mental health services to clients identified by gender, race and ethnicity. Eighty percent of the returned questionnaires failed to provide the data requested, thus no meaningful breakdown related to these categoires can be given.

Comments received from CMHCs suggest that, due to changes in reporting requirements accompanying the block grant program, general, as well as specific data, such as those related to minorities, may not be collected on a routine and systematic basis. This is particularly unfortunate because this lack of adequate information will not only impede policy planning and the development of delivery systems, but also affect the assurance that services are provided equitably to all groups.

Comparison of Community Mental Health Centers
Reporting Adverse And No Adverse Effects

Relatively few differences were found between CMHCs that reported a negative impact of the ADMS block grant program and those that did not. Fifty-two percent of CMHCs currently receiving federal funding reported adverse effects from the block grant program. Not surprisingly, those that reported a negative impact received significantly less federal dollars in both the 1983 (*2 - Volume II) and the 1982 budget years (*3).

CMHCs Having Aging Programs Reported
Adverse Effects Due to Block Grant Funding

There were significant differences in the numbers of elderly clients served between those CMHCs that reported adverse effects and those which did not. Specifically, the CMHCs reporting adverse effects had seen more elderly clients than those who reported no adverse effects (*4) and this was true for both male (*5) and female clients (*6). These results appeared only in the 1983 budget year, and, therefore, are probably not due to pre-existing differences.

A noteworthy difference emerged concerning the presence or absence of an aging program between those CMHCs which indicated adverse effects and those which indicated no adverse effects. A higher proportion of CMHCs that claimed adverse block grant program effects indicated the existence of an ongoing aging program (*7), and were more likely to have had an aging program prior to the block grant (*8).

Affected	Current Aging Program	Prior Aging Program
Yes	65%	81%
No	47%	47%

The CMHCs indicating adverse effects reported seeing significantly more elderly clients than those that were not adversely affected. This difference was independent of the total number of clients seen, since there were no significant differences in the number of visits for these CMHCs during the pre- (*9) or post-block grant (*10) period. No significant differences were found in the percentage of visits by older people from the 1981 pre-block grant (*11) to the 1983 post-block grant period (*12).

Adverse Effects on Clinical Services and Staff

Of the 109 (or 48%) CMHCs reporting adverse effects, 83 (or 76%) indicated that reductions in clinical services had been required as a result of the block grant program. Staff had been reduced at 82 (75%) of the CMHCs, while 46 (42%) indicated adverse effects on administrative or clinical record keeping.

Many respondents indicated "other" negative effects of the block grant program. Five centers volunteered the information that the block grant had adversely affected their geriatric services, and detrimental impact on outreach activities was indicated by eight centers. Consultation and education activities, as well as prevention services, were reported to have been reduced at 17 CMHCs. One CMHC noted that changes or limitations in support services (e.g., maintenance, supplies, equipment) had been necessary. Plans for expansion were curtailed at three centers.

It is possible that the number of programs that were negatively influenced by the block grant system (in areas such as services to older clients, consultation and education, prevention, outreach, support services, and expansion planning) may have been underestimated from the available data since respondents were not asked to reply separately for each of these program directions.

No Regional Differences Were Found in the
Adverse Effects of the Block Grant Program

There were no significant regional differences in response to the question -- "Has your Community Mental Health Center Program been adversely affected due to the initiation of the federal ADMS block grant program?"

However, one difference that was found pertained to the proportion of CMHCs receiving federal ADMS funding. This difference occurred in both pre-block grant and post-block grant budget years. Over 40% of the CMHCs receiving federal funds were from the South, while only slightly over 11% were from the West, and the Northeast and North Central had 18% and 25% respectively. These percentages, however, are almost identical with the distribution of the total sample. Moreover, it is important to note that there were no significant regional differences in the actual number of dollars received from any one of the funding sources.

Survey Limitations

Several points should be emphasized relative to the present data. There were incomplete data for many items on the questionnaires. Clear-cut conclusions about the effects of block grants on services to elderly clients are complicated; for instance, when a given Community Mental Health Center provides information on the level of block grant funding, but not on the proportion of total client visits made by elderly persons.

The incompleteness of many returned questionnaires may have been due to the length of the survey instrument and the complexity of the data breakdown that was requested. Several respondents complained that the survey required far more than ten minutes to complete. Also, information was requested in a form that was not always readily accessible to the CMHCs. The problems (and distortion) involved in providing such generally unavailable data is illustrated by the fact that in three cases duplicate questionnaires were received from the same CMHC, and perhaps more importantly, discrepancies in the data on two of the three cases was sizable.

There were also instances of inconsistent responses within a given questionnaire. For example, a respondent might identify 30 professional staff members in response to one item, but elsewhere give a total of 34 when asked to provide a racial breakdown of the same staff. Some of these problems may have been due to the complexity of questionnaire items. These data collection problems illustrate the need for some minimal level of required reporting by the state to the federal government regarding the facts and figures for critical services.

Statistical inference is based on the premise that an obtained difference between samples may not reflect actual differences between the two populations from which they were drawn, but may simply reflect chance variations due to sampling error. Statistical analyses involve the computation of the probability that the observed results may be due to chance or sampling error. A convenient rule commonly adopted by researchers is that, if the probability that obtained differences are due to chance is assessed to be less than 1 in 20 ($p < .05$), then such sample differences are regarded as reflecting true population differences. The amount of variability obtained within a group of scores is also taken into account in statistical analyses. Although, at first glance, mean differences may appear to be large, a lack of statistical significance may result from differences in variability. Therefore, variability must also be taken into account to minimize the bias that extreme scores might have on the results.

The data from the reported CMHC survey demonstrated considerable variability. Some CMHCs experienced large funding cuts, other small cuts, and a few indicated slightly increased funding. This variability suggests caution in generalizing from the present results about the effects of the block grant program on CMHCs.

Conclusions

The survey of Community Mental Health Centers conducted by the Action Committee demonstrated that, on the average, CMHCs received significantly fewer federal funds after the implementation of the federal ADMS block grant program as compared to before. The loss in federal funding appears to have been partially replaced by other sources (local funding and fees, but not state funds). When inflation effects are included in the overall picture, this "loss" becomes more significant. Half of all CMHCs indicated they had been adversely affected by the block grant program. However, for the total sample, there had not been any decrease in the total amount of services provided after one year.

The results of the survey indicate that the elderly continue to be underserved by CMHCs, and there is great variability in the geriatric services that are available in differenct communities. It appears that the number of CMHCs offering specialized mental health services to the elderly, after increases during the 1970s, has been declining during the early 1980s. CMHCs that reported adverse effects due to the block grant tended to be Centers that provided elderly services.

Chapter III

SITE VISITS TO COMMUNITY MENTAL HEALTH CENTERS AND AREA AGENCIES ON AGING

Summary of Site Visit Findings

- o CMHCs reported adverse effects on their activities related to block grant funding.
- o Block grants had a negative impact on geriatric services.
- o There has been reduced support in CMHCs for specialized aging programs.
- o Many factors contribute to the underservice of the aged.
- o CMHCs reported little contact with Area Agencies on Aging.
- o Aging programs are aware of the mental health service needs of their clients.
- o AAAs and CMHCs reported almost no coordinated service delivery and little routine interaction.
- o There is need for cooperation between the mental health and aging services networks.
- o The mental health system should be innovative in the delivery of services to the elderly in the community.
- o There is a need for in-service mental health training for aging service staff.

This chapter will present background information on the Community Mental Health Centers and Area Agencies on Aging obtained during site visits, along with summary findings from the CMHC and AAA interviews.

The Site Visits: Introduction

There were two major purposes for the site visits. First, more complete information about the impact of the block grant on Community Mental Health Center programs was needed in relation to general and age-related services. Second, there was an interest in the nature and extent of interagency contact and cooperation between Community Mental Health Centers and Area

Agencies on Aging, and the impact of interagency collaboration or non-collaboration on agency clients. Accordingly, each site visit entailed at least three interviews: one with CMHC personnel, one with AAA or aging office personnel, and one with a client of both agencies. Action Committee staff generally arranged the CMHC and AAA interviews, but the local organizations handled arrangements with their clients. In several instances additional interviews were arranged with other direct service, county or regional planning and coordination agencies.

Selection of Visit Sites: The survey questionnaire asked if the respondent would agree to an in-depth interview; 107 (46%) of the responding CMHCs answered positively. The criteria used in selecting the sites to be visited were: 1) the sample should be mixed demographically so as to include urban, suburban, and rural areas, and also represent, to the extent possible, a range of service delivery strategies; 2) the sample should include the country's major geographic regions; 3) the sample should include CMHCs with high and low percentages of elderly in their catchment areas; 4) the sample should include CMHCs that reported high as well as low percentages of elderly served; 5) the sample should include CMHCs with specialized aging programs, as well as those without such programs; 6) the sample should include centers that reported adverse effects, as well as those that reported no negative effects due to the block grant; 7) the sample should include only CMHCs where the local Area Agency on Aging would also agree to a site visit and interview; and 8) the sample should include CMHCs located in Congressional districts of Representatives and Senators serving on committees with jurisdiction over issues of concern to mental health and the aged, since these members should be particularly interested in the data generated by the study.

Using these criteria, eleven localities were selected for the site visits that were conducted between July and September 1983 by Action Committee interviewers.

Interviews were conducted informally, although interviewers had "interview guides" available that were prepared by project staff (See Volume II). These guides served as a framework for the data collection. The interviews produced data that could be compared across all locations as well as data specific to the programs and catchment areas being studied.

CMHC Interviews: In the interviews there was an interest in obtaining additional detailed information about the general impact of the block grant on the overall operation of the Centers and on the composition of the client population. There was also an interest in the effects of the deinstitutionalization movement on both the overall client population and particularly the older CMHC client population. With respect to the Center's aging clientele, the intent was to learn about the Center's perceptions of mental illness prevalence rates among the elderly within the community and any reasons for under-utilization of services by older adults. Inquiries were also made as to whether or not the Center had conducted an assessment of mental health needs of the elderly in its catchment area.

If the CMHC had a specialized aging program, information was sought about the specific services provided to older clients. If there was not a specialized aging program, an effort was made to learn why there was not (particularly in cases where aging programs had been discontinued) and to identify any plans for the development (or reinstatement) of such aging components.

Another set of questions explored the types and frequency of interaction between the CMHC, the AAA, local nursing homes, and other community and state organizations delivering mental health and/or aging services. Also solicited were CMHC views regarding the effectiveness of shifting funding responsibility from federal to state and local government and to the private sector. The final question inquired as to whether the CMHC was the most appropriate local agency for the delivery of mental health services to older adults.

AAA Interviews: Interviews with AAAs were more general in nature than those with CMHCs since the site visit represented the first substantive contact with these offices. Interviewers requested information on the background of aging program services, funding patterns and data on any mental health related services, the nature of mental health problems experienced by local older clients and the impact of that clientele on existing programs, and the need for staff training in mental health and aging. The agency staff were also asked if they had ever conducted a community-wide assessment of the needs for geriatric mental health services.

As in the CMHC interviews, aging office staff were asked about the nature and extent of their interaction with the CMHC (and other mental health and/or aging programs providing direct services to the mentally ill elderly). There was also an interest in the aging staff's view as to whether or not the local CMHC was meeting the mental health related needs of older clients (and, if not, why). Also sought was the staff's assessment as to whether state and local governments and the private sector would be capable of assuming increased financial responsibility for local programs. Finally, inquiry was made as to which agency the AAA/aging office staff felt was the most appropriate focal point for the delivery of mental health services to older adults.

Client Interviews: The interviews with clients were intended to solicit relevant but subjective and non-clinical information regarding the quality, types, and extent of services received from the local CMHC and the aging offices. There was also an interest in learning about any program service needs that were not currently being met by one or both service systems. Clients were also asked about the role that their families/significant others have played in facilitating and fostering client interaction with the mental health and/or aging program offices. In addition, questions were asked about who the client turned to in crisis situations (i.e., CMHC, aging offices, other community agencies or family/significant others).

In general, the client interviews were non-productive. The respondents were often guarded in giving information or showed little understanding about the structure or function of the service systems. Therefore, depth analysis of client interview data was not carried out.

Summary findings from the CMHC and AAA/aging office site visits are presented to provide additional information about the agencies that complements the mail and telephone surveys. Most of the agencies did provide some common data relating to the major issues addressed by the interview.

Community Mental Health Center Interviews - Summary Findings

CMHCs Reported Adverse Effects on their Activities Related to the Block Grant Funding

Seven of the eleven CMHCs interviewed had earlier reported negative impact from the block grant program. Six of these confirmed their earlier impressions during the site visits, while one agency appeared more "neutral" as to the impact of the block grant. Of the four agencies that had earlier reported no negative impact, only two confirmed their earlier impressions. The remaining two indicated that, while they had sustained no negative impact to date, they anticipated funding problems in the next budget year. Thus, eight of the eleven CMHCs visited had already experienced or anticipated negative impact as a result of the block grant program.

Negative Impact on Geriatric Services

Program changes cited as a result of the block grant system included reductions in outreach, transportation, aging and general program staff; reductions in prevention, consultation and education activities; increased caseloads and waiting lists; shifting of program priorities from direct service/outreach to a case management orientation; and the targeting of services to chronic and severe cases and away from those of the moderately impaired.

CMHCs Able to Maintain Specialized Aging Programs

Nine of the sites visited had aging programs (though one of these was operated by only one full-time staff person, and another consisted of one half-time staff person). The other two sites had programs which had been discontinued, in one case because of block grant budget reductions, and, in the other case because of a shift of state priorities toward a general or non-categorical style of programming.

Deinstitutionalization Movement Had Little Impact on Services to the Aged

Based on site visit interviews with CMHCs, the deinstitutionalization movement was having little immediate impact on CMHC services for older adults. Several CMHCs reported that most of the deinstitutionalized older persons in their catchment areas had been referred directly to nursing homes. The CMHCs tended to have infrequent interaction with state and county hospitals. Several locations indicated that their states had assigned priority service to the chronically mentally ill. The caseloads of elderly with chronic mental health problems were reported not to have increased significantly in recent years, although many of the CMHCs did provide a relatively high proportion of inpatient and transitional care to older adults.

Prevalence of Mental Illness

Only three CMHCs had conducted a formal mental health needs assessment survey on older adults in their communities. All agencies interviewed, however, offered informal assessments as to the prevalence and type of emotional problems that appeared to be experienced by their older clientele. The most common problems cited were drug misuse, depressive conditions, and alcohol abuse. Organic brain syndromes and schizophrenia were cited at much lower prevalence rates.

Many Factors Contribute to the Underservice of the Elderly

The CMHCs cited the need for more specialized outreach, home care and transportation programs, along with adequate funding to enable such programs to achieve optimal participation by older clients. Many agencies also cited the need to overcome negative stereotyping by the elderly of mental health services, as well as the need to overcome negative impressions of older clients held by mental health professionals through educational programs for both older adults and mental health professionals. Many of these recommendations were similar for both mental health and AAA/Aging Office staff.

CMHCs Reported Little Contact With Area Agencies on Aging

CMHCs with aging programs reported fairly routine contact with the aging direct service network, but relatively less contact with Area Agencies on Aging. This appeared to be true for all CMHCs with aging program staff. CMHCs with small staffs frequently had more routine contact with other direct service agencies since the majority of their efforts were directed toward consultation and education activities, rather than direct servcies. Most of the contacts were related to referrals. CMHCs without specialized aging programs had little contact with the Area Agencies on Aging. Interestingly, the CMHCs did not perceive that the block grant had had any impact on the nature of their interaction with other agencies.

Future Directions

Agencies responding to the question about alternative funding sources to replace lost federal funds indicated a universal lack of faith in the possibilities for private sector financing. In general, they tended to rely on state and local government to augment those gaps created by the loss of federal dollars from their programs.

All agencies responding to the question about the local agency best equipped to provide mental health services to older adults felt that the CMHCs should do so.

Area Agency on Aging Interviews - Summary Findings

The majority of the aging offices contacted were local planning and administrative agencies that did not provide direct services. However, all agencies were questioned regarding services that they provided either directly or indirectly through contract agencies. Most of the agencies indicated that they provided mental health-related services such as general and specialized counseling, telephone reassurance, friendly visiting, short-term crisis intervention, mental health referral, protective services, and case management. While most mental health problems of a serious nature were referred to CMHCs, several AAAs/aging offices directly coordinated service management with the CMHC. In several cases, the CMHC provided clinical services within aging programs.

Outreach and Home Care Programs Needed Within the Mental Health System

Agencies cited the need for mental health outreach and "home delivery" of mental health care. Thus, the aging office responses to this question were similar to those by the CMHCs. They also stressed the need for education and training of mental health professionals about older adults and the need for public education about mental health and illness directed towards the elderly.

The Ability of the Aging Services Staff to Identify the Mentally Impaired Elderly

While only one of the Area Agencies on Aging interviewed had conducted a thorough needs assessment, most felt that the mentally impaired elderly in their community were not adequately served. Types of mental impairment that was cited included depression, "senility", alcoholism, and drug misuse. Less frequently mentioned were a variety of symptoms of strange or disturbing behavior (which, when encountered, were usually handled by referrals to the mental health system) often identified initially by home care providers, such as Meals-on-Wheels staff. In general, aging offices seemed to handle the more routine/frequent problems through ongoing programs and services.

The Need for In-Service Mental Health Training for Aging Service Staff

Several of the aging offices had undertaken limited in-service mental health training for their direct service staffs. In several cases, the CMHCs had provided the training, and it was universally agreed that there was a need for both more intensive and extensive training. Much of the current training focused on the identification of severe and chronic mental illnesses, rather than on understanding and dealing with the more common emotional and behavioral problems frequently experienced by their aged clients. Most of the training was directed toward helping agency staff in making referrals, with little emphasis on the problems and techniques of assessment and intervention.

AAAs Reported Little Interaction With CMHCs

Only four of the aging offices interviewed reported weekly (or more frequent) interaction with CMHCs. These agencies tended to deal more

frequently with non-mental health human services, such as welfare offices, social service agencies, nursing homes, and other aging service providers. Seven of the aging offices cited mutual efforts with local nursing homes, which included friendly visitors, advocacy, placement and discharge planning and ombudsman programs. Contacts were generally related to referrals for service rather than ongoing care. While several aging offices noted increased difficulty in making successful referrals due to budget cuts sustained by other agencies, an increased sense of interagency cooperation was noted as a result of reduced budgets, since agencies were increasingly relying on each other for coordinating service delivery. Unfortunately, this spirit of interagency cooperation apparently had not yet extended to the CMHCs.

Funding Changes Experienced by AAAs

Only two of the aging offices interviewed had experienced an overall loss in funding over the past year so that the majority of the programs were maintaining previous funding levels. This has added to the prestige of aging organizations within the human services community and has probably contributed to the previously mentioned improved spirit of cooperation. Two agencies, however, did have significant net losses in federal funds due to the elimination of CETA slots and reductions in Title XX allocations. While other agencies had experienced similar reductions, they had been successful to date in augmenting their program funds with Title V (Older Americans Act) employment grants and with state and local funding.

Responsibility for the Delivery of Geriatric Mental Health Services

Of seven organizations responding to the question as to which agency should serve as the focal agency for the delivery of mental health services to the elderly, only three indicated that the CMHC should continue to fulfill this role. Three indicated that AAAs should have this responsibility (given increased funding and authorization under the Older Americans Act). The last agency suggested that hospital psychiatric units should serve this function.

Chapter IV

RECOMMENDATIONS

Summary of Recommendations

The following recommendations are based on the findings of the Action Committee survey and site visits as well as the mental health related recommendations from the 1981 White House Conference on Aging:

Recommended Federal Reforms

- Abolish the block grant system of service funding.
- Reinstate a categorical system of mental health service funding.
- Expand Medicare mental health benefits to a level which parallels medical benefits coverage.
- Amend the Older Americans Act to assure a coordinated approach between Area Agencies on Aging and Community Mental Health Centers in meeting the mental health and psychosocial needs of the elderly.
- The Federal Government should take administrative action to assure that the interagency agreement previously developed between the National Institute of Mental Health and the Administration on Aging mandating mental health and aging service systems cooperation in the development and provision of psychosocial services to the elderly be implemented in an expeditious manner.
- Implement the Older Americans Act requirement that Title IV grants for mental health demonstration programs for older adults require the incorporation of the full range of mental health service needs of the aged.

Recommended State Reforms

- State Agencies on Aging and State Departments of Mental Health should take administrative action to assure coordination and cooperation in their planning, development, resource allocation, and service delivery in order to provide and support an adequate continuum of psychosocial services to meet the diverse needs of older adults.

- State governments should enact legislation to establish specifically targeted programs addressing the mental health needs of the elderly in all state mental health systems.

- The directors of State Agencies on Aging, State Departments of Mental Health, and directors of local Area Agencies on Aging and Community Mental Health Centers should assume an advocacy role on behalf of comprehensive mental health services for older adults before state legislatures, the Administration, and the Congress.

- Full mental health coverage should be restored and maintained under Medicaid at the 1981 level (with allowances for inflation).

- State Agencies on Aging and State Departments of Mental Health should initiate in-service training programs in mental health and aging at both the state and local levels for mental health and aging service personnel.

Recommended Local Reforms

- Local Area Agencies on Aging and Community Mental Health Centers (and other mental health and aging service providers) should initiate formal inter-system coordination and interaction for the assessment, planning, development, and delivery of comprehensive mental health services to the aged.

- Community Mental Health Centers, and other public and privately funded mental health programs, should insure that adequate and suitable services are being delivered on an equitable basis to the aged and particularly to the minority elderly.

- Local aging networks and the mental health system should initiate joint training sessions for mental health and aging service providers at the community level.

- Joint case management systems, involving both the aging and mental health networks, should be developed at the community level.

- Interagency community action networks should be established at the local level to develop cooperative planning and program development for a continuum of mental health services for the aged.

This chapter will review the major findings of the survey and the site visit reports, review the relevant mental health recommendations from the 1981 White House Conference on Aging, and make recommendations for reforms at the federal, state and local levels.

Review of Major Findings

Adverse Impact of the ADMS Block Grant Program

Forty-eight percent of the CMHCs responding to the survey reported adverse effects due to the block grant system of funding and these reports were nationwide rather than being limited to any geographic region. The adverse effects, related to decresed funding that required staff reductions and limitations on core activities such as clinical services, outreach programs, and consultation, education, and support services. In addition, the plans of several centers for an expansion of elderly services had been curtailed.

The Aged Remain an Underserved Population

It has been pointed out above the the aged comprise over 11% of our national population, but are estimated to receive only 6% (overall) of the services from CMHCs, and even less from private mental health programs and practitioners. While there has not thus far been a significant decrease in geriatric services due to the block grant system, such services have not increased to adequately meet their mental health needs. Nor has funding been available to initiate innovative or outreach programs to assist the minority, rural, frail or homebound elderly. Thus, the 1981 White House Conference on Aging recommendation that staff and funds for geriatric mental health services be allocated proportionate to the percentage of older adults in the CMHC catchment area (#120-A) is currently not being implemented.

The Racial and Ethnic Minority Elderly Are Severely Underserved

The mental health needs of racial and ethnic minorities have been largely neglected by both public and private mental health systems. Also, there has not been a thorough assessment of their mental health needs and beyond that prevention and treatment programs have not been designed to meet those needs. Cultural and language barriers often serve to inhibit the request for, and delivery of, services to these elderly. The 1981 White House Conference on Aging recommended that geriatric mental health care be given in a way that respects sensitivity and awareness of ethnic and cultural differences (#16) but, clearly, little has been done in reaction to this recommendation.

Decreases in Specialized Aging Programs

The general reduction in federal support for mental health services has had a negative effect on specialized aging programs. While the pre-block grant era was one of expansion of aging programs, the post-block grant period has resulted in the termination of many specialized programs. More terminations are also anticipated as the impact of the block grant permeates the mental health system. In contrast, the 1981 White House Conference on Aging recommended the expansion and development of appropriate mental health servies for older adults (#145).

There is Little Interagency Cooperation Between the Mental Health and Aging Service Networks

CMHCs in the present study reported routine interaction with AAAs, but little cooperative efforts in the planning, development, resource allocation, or delivery of mental health and psychosocial services to the aged.

CMHC Staff Often Lack Training in Gerontology

The professional training of CMHC staff frequently has not included information about the mental health needs of the elderly or the treatment methods that might be most appropriate for use with older clients. In-service training programs also appear to neglect problems of and services to the aged. As a consequence, mental health professionals often are not knowledgeable about geriatric treatment and tend to avoid working with the elderly. Related to this, the 1981 White House Conference on Aging recommended that all personnel involved in the delivery of geriatric services should be required to have gerontological or geriatric training (#429).

Recommended Federal Reforms

The Action Committee recommends several reforms at the federal level to improve the delivery of mental health services to the aged.

Recommendation No. 1

Abolish the block grant system of service funding. A major limitation of the block grant approach to funding with respect to the elderly, and other special needs populations, is its lack of requirements for the uniform availability of services on a nationwide basis. While the block grant program does include some provision for specialized geriatric services, it has not been consistently implemented. States are left to develop their own priority areas for mental health funding, and the result has been that aging services have often been relegated to the bottom of the list. This has resulted in considerable variations among states in the amount and types of targeted services for the elderly, and it provides little incentive to CMHCs to develop innovative service delivery programs to meet the mental health needs of the aged. Thus, as a result of funding patterns and priority designation, the elderly have remained a severely underserved population within the CMHC system.

Recommendation No. 2

Reinstate a categorical system of service funding, such as the service component of the Mental Health Systems Act of 1980 that allowed for the designation of specialized services for the aged and other special groups. This system would help to create a national priority for uniform planning, development, and delivery of mental health services. It should also help to establish a partnership between governments at the federal, state, and local levels to provide mental health services to unserved and underserved target groups.

Recommendation No. 3

Expand Medicare mental health coverage to a level which parallels medical benefits coverage. The Congress should eliminate Medicare's institutionalized bias against those suffering from nervous and mental disorders, and provide coverage which is equal to the benefits available for physical disorders. The following Medicare revisions are recommended:

1. the reimbursement ceiling for mental health services currently at $250, be eliminated;

2. the Medicare Part B co-insurance requirement for mental health care be established at 20% for the recipient as it is for physical health care;

3. outpatient mental health services be made more accessible to the elderly by expanding the definition of approved mental health treatment providers to include all of the four core mental health professions (psychiatric nurses, psychiatrists, psychologists, and social workers);

4. the 190 day lifetime limit on inpatient treatment for nervous and mental disorders be abolished.

The Action Committee shares the concerns of the general public regarding the escalation of health care costs. It stands ready to work with the Congress in helping to develop more cost effective service delivery systems which do not discriminate against either classes of beneficiaries or providers. This might be accomplished through health financing reform, the development of prospective payment systems, patient classification systems, the shifting of mental health care to social/health maintenance organizations, or by other viable cost reduction/containment alternatives.

Recommendation No. 4

Amend the Older Americans Act to assure coordination between Area Agencies on Aging and Community Mental Health Centers in meeting the mental health and psychosocial needs of the elderly. Title III of the Older Americans Act should be amended to authorize Area Agencies on Aging to make grants related to the social needs of the mentally impaired elderly. This amendment should direct the Area Agencies to develop working agreements with Community Mental Health Centers, and other organizations providing mental health services, in order to assure coordination in meeting the mental health and social needs of the aged. A separate appropriation should be provided for the operation of such programs rather than requiring the Area Agencies to do so out of existing funds.

Recommendation No. 5

The federal government should take administrative action, as necessary, to assure that the existing interagency agreement between the National Institute of Mental Health (NIMH) and the Administration on Aging (AoA) mandating mental health and aging service systems cooperation in the development and provision of psychosocial services to the elderly be implemented in an expeditious manner. Both NIMH and AoA are administered by the Department of Health and Human Services so that agreements for the coordination of services can be developed and supervised through the initiative of the Secretary and Assistant Secretaries of HHS, by the Commissioner on Aging, and appropriate administrators, directors and divison chiefs.

In addition, AoA and NIMH should actively promote the development of interagency agreements at the state and local levels. State agencies on aging and state departments of mental health should coordinate their planning, development and delivery systems in providing psychosocial services to the aged. These efforts would be in addition to, but supportive of, the local CMHC/AAA activities referred to in Recommendation No. 4.

Recommendation No. 6

Implement the Older Americans Act requirement that Title IV grants for mental health demonstration programs for older adults incorporate the full range of geriatric mental health services. The 1981 amendments to the Older Americans Act (P.L. 97-115) included a section in Title IV requiring that special mental health demonstration programs be developed for older adults. In awarding grants and contracts under this section, the Commissioner on Aging was directed to give special consideration to those projects relating or designed to identify and meet the special health care needs of the elderly. Also singled out for emphasis were mental health needs and services, community and nursing home facilities, and staff training in these facilities.

Unfortunately, in spite of the intentions of Congress in enacting these provisions, the Administration on Aging, to date, has not issued a grant announcement which incorporates the full range of issues included in the 1981 amendments. Accordingly, the Congress should require some direct provision to meet the intent of the Act. Such provisions should provide for the allocation of funds, and the timely issuance of regulations and specific program announcements.

Recommended State Reforms

The Action Committee recommends several reforms at the state level which would serve to improve the delivery of mental health services to the aged.

Recommendation No. 7

State Agencies on Aging and State Departments of Mental Health should take administrative action to assure coordination and cooperation in their

planning, development, resource allocation, and delivery of service in order to develop and support an adequate continuum of psychosocial services to meet the diverse needs of older adults. Coordination at the state level would serve to encourage similar efforts between local aging networks and mental health organizations.

The mental health component of this coordination initiative might include the development of mental health services in long-term care facilities, mental health outreach programs for the functionally impaired and homebound aged, and improved mental health service delivery to the poor and minority elderly. In addition, cooperative efforts at the state level could more strongly encourage the exchange of knowledge and technical assistance, as well as joint financing of needs assessments, geriatric programs, and in-service staff training.

Recommendation No. 8

State governments should enact legislation to establish programs specifically targeted to the mental health needs of the elderly in all state mental health systems. Presently, under the block grant program, states determine the priorities for services through the CMHCs. While they can adjust mental health service priorities through administrative action, it is believed that state legislatures should mandate and insure the delivery of a full range of services to the elderly, and other special needs populations, by force of law. The legislation should also require the establishment of specialized aging programs throughout the Community Mental Health Centers systems.

Emphasis should also be given to the delivery of badly needed mental health and psychosocial services to minority and rural elderly since these two groups are particularly underserved segments of the aged population. In addition, state legislatures should give special attention to the development of meaningful affirmative action programs for the recruitment, hiring, training, and promotion of minority staff and professionals by aging and mental health agencies at both the state and community levels.

Recommendation No. 9

The directors of State Agencies on Aging, State Departments of Mental Health, and directors of local Area Agencies on Aging and Community Mental Health Centers should assume an advocacy role in the development of comprehensive mental health services for older adults -- before state legislatures, the Administration, and the Congress. Many directors are already active and effective advocates on behalf of services for the aged. However, the mental health needs of the elderly, in particular, should be strongly emphasized before those governmental bodies responsible for determining that adequate services are funded and made available and accessible to the elderly.

Recommendation No. 10

Restore and maintain full mental health funding under Medicaid at the 1981 level (with allowances for inflation). Many states have reacted to budget reductions by decreasing mental health coverage under Medicaid. This tends to discriminate against those poor who are mentally impaired and those for whom alternate treatment does not exist or is not accessible. This trend should be reversed so that State Medicaid plans are able to provide needed inpatient and outpatient mental health services for low income elderly through CMHCs and other public/nonprofit mental health systems.

Recommendation No. 11

State Agencies on Aging and State Departments of Mental Health should initiate in-service training programs in mental health and aging at the state and local levels for mental health and aging service staff. It is recognized that service providers may desire to help older clients, but lack knowledge about their specific needs and problems. The in-service training programs might include a coverage of topics such as: The most common and serious mental health needs and problems of the elderly (including those who are functional but "at-risk", homebound, physically handicapped, nursing home elderly, etc); appropriate intervention strategies and techniques that might be employed with the mentally impaired elderly (and their families); the types of geriatric mental health services that are available on a state and county basis; and the effective techniques that mental health and aging organizations might use in improving inter-system referrals, interaction, and cooperation.

It is recognized that severely reduced federal support for both gerontological and clinical training will exacerbate the already existing shortages of professionals that are available to assist in training programs. It is, therefore, important that a cadre of expert and knowledgeable trainers be developed as quickly as possible. Federal and state governments should cooperate in jointly funding programs to produce a core of aging and mental health professionals that could develop additional personnel. On a short-term basis, this would allow some existing agency staff to become better informed than they currently are about the needs and problems of the elderly and the sevices that they require. Title IV (Older Americans Act) training funds should be used to prepare this cadre of trainers.

For long-term mental health and psychosocial planning, both state governments and the federal government should recognize that the currently projected increases in the number of older persons in this country will require significant increases in the trained personnel that are available to meet their needs.

Recommended Local Reforms

The Action Committee recommends several reforms at the local level to improve the delivery of mental health servces to the elderly.

Recommendation No. 12

Local Area Agencies on Aging and Community Mental Health Centers (and other mental health and aging service providers) should initiate formal inter-system interaction and coordination for the assessment, planning, development, and delivery of comprehensive mental health services to the aged. Beyond federal and state governmental initiatives, formal working agreements between mental health and aging services systems must be established at the local level. Cooperation at the local level is crucial in assuring that older adults will receive equitable treatment from the aging and mental health service networks.

Recommendation No. 13

Community Mental Health Centers, and other public and privately funded mental health systems, should ensure that adequate and suitable services are delivered on an equitable basis to the aged and particularly to the minority elderly in the community. As previously indicated, the elderly represent over 11% of the population, but generally receive only 6% or less of CMHC services. Adequate delivery of services should include innovative mental health outreach efforts for those elderly not reached by traditional mental health services; who are in nursing homes and other long-term care facilities; homebound and functionally impaired; are residing in rural areas; and who are poor and/or minority group members. It is recognized that the elderly present a difficult challenge to the mental health system in terms of the delivery of services because of the way in which the system is presently organized. Nevertheless, the underserved and unserved elderly must be helped through special and innovative programs and/or restructuring of the present delivery system.

The CMHCs should identify and assess the mental health needs of the racial and ethnic minority aged in their catchment areas and develop prevention and treatment programs designed to meet their particular needs. In addition, to improve the acceptance and utilization of mental health services by minority elderly, minority and bilingual staff and professionals should be trained and employed in the treatment centers and facilities should be located in or nearby the ethnic community. Outreach efforts should involve already existing ethnic organizations (i.e., churches, community groups, etc.). Mental health service personnel should develop an understanding of the cultural backgrounds, values and beliefs of the different racial and ethnic groups that they serve, and develop expertise in culturally relevant treatment modalities.

Recommendation No. 14

Local aging networks and mental health systems should initiate joint training sessions for mental health and aging service providers at the community level. In-service training sessions could serve to stimulate inter-system interaction and exchange of information on such topics as: cross-system referrals; psychological and social needs of the elderly; and specific training in geriatric service delivery. Such interaction might well serve as a critical point of contact and information exchange among service systems to heighten the awareness of the needs and problems of the aged, to encourage mutual awareness and appreciation among agencies of the need for the services that they provide, and to reduce the isolation that characterizes the aging services network in many communities.

Recommendation No. 15

Joint case managment systems involving both the aging and mental health networks should be developed at the community level. Case management may be described as the coordination of needed services on behalf of the elderly client, including development, implementation and review of individual service and treatment plans (Mental Health and Aging Advisory Group, 1983). The implementation of an effective case management system would help to assure that the elderly will receive appropriate mental health and social services. It would also serve to stimulate the development of a client management record system to facilitate follow-up after referrals among agencies as well as routine inter-staff consultation and cooperation in dealing with the problems of clients.

It is recognized that the effectiveness and operational characteristics of a given case management system will depend on the organizational history and the availability and strength of community resources. Some communities may tend to draw on certain resources, such as a Community Action Program, in assisting the elderly in need of mental health and related services, while other communities may prefer to use the Area Agency on Aging or the Department of Human/Social Services.

Recommendation No. 16

Interagency community action networks should be established at the local level to develop cooperative planning and program development for a continuum of mental health services for the aged. The objectives of the action networks might include: increased recognition within community agencies and programs for the mental health needs of the aged; advocacy on behalf of such needs; helping to make the needs understood by decision-makers at the local, state and federal levels; and identifying strategies to effectively and cooperatively meet these needs (Mental Health and Aging Advisory Group, 1983). The action networks might include representatives from organizations such as: Area Agencies on Aging, Community Mental Health Centers, departments of social service, public health departments, hospitals, religious institutions, legal services, the judicial system, institutions of higher

education, and other entities interested or involved in the problems of older adults.

Final Comments

This chapter has presented the Action Committee's recommendations for federal, state and local governent reforms. These recommendations are based on a variety of previous reports and published research as well as the information collected from a Community Mental Health Center survey and site visits. The recommendations are intended to suggest ways of improving the quality and availability of mental health services to all of the aged in this country.

As the purpose of the research project was to assess the impact of the ADMS block grant on the delivery of mental health services to the elderly in this country, this report has focused primarily on deficiencies in the mental health system and current mental health policies. Nevertheless, the Action Committee would also like to formally recognize and commend the Community Mental Health Centers and the Area Agencies on Aging for the substantial contributions they have made to the health and well-being of our nation's elderly through the dedication and hard work of their mental health professionals.

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